FY 2017 Benefits *Change* Form

Employee #: _____ Name (Last, First, MI): _____

Address: _____

City, State Zip: _____ Date of Birth: _____

Phone: *(Home)* _____ *(Work)* _____

(Cell) _____ E-mail Address: _____

DEADLINE

THE BENEFITS OFFICE MUST RECEIVE YOUR COMPLETED PAPERWORK WITHIN 31 DAYS OF THE DATE OF THE LIFE EVENT IN ORDER TO PROCESS YOUR REQUEST (60 days for birth/adoption of child). Please see the Insurance Handbook at www.tucsonaz.gov/enroll for additional information.

EFFECTIVE DATE OF CHANGE

Your changes will take effect the first of the month following the date of the event for any event, except:

- → If the event is birth/adoption, your changes take effect on the date of the birth/adoption
- → If the event occurs on the first day of the month, your changes take effect on the date of the event; if the event occurs on the second or later day of the month, your changes take effect on the first day of the following month

Date of Life Event: _____

Type of Life Event: ☐ Change in Hours ☐ Change in Spouse's Insurance ☐ Loss / Gain of Dependent Status ☐ Change in family status (divorce, marriage, birth or adoption of child) ☐ Other

Description of Qualifying Life Event: _____

_____

What kind of changes would you like to make? ***(Please be specific. Example: "I want to add my new son to my medical HMO and dental PPO." Please be sure to list specific plans.)*** _____

_____

If you are adding dependents, for each new enrollee, please provide LEGAL NAME, SSN and DATE OF BIRTH:

_____

REQUIRED DOCUMENTATION: ***If your life event is…***

Marriage: Copy of marriage License (Marriage generally allows you to add people to coverage, but not to drop coverage. To drop coverage, you must furnish proof that you've newly gained qualifying coverage elsewhere.)

Divorce: Copy of 1st and last pages of divorce decree

Ex-spouse's mailing address (for COBRA): _____

Birth: Copy of birth certificate ***Adoption***: Copy of adoption papers

Loss of Other Coverage: Documentation proving loss of other coverage (type of coverage and date of loss)

Gain of Other Coverage: Documentation proving gain of other coverage (type of coverage and date of gain)

Name Change: Copy of new Social Security Card ***(NOTE:*** *Be sure to also change your name with Payroll and Pension.)*

I have received and read the materials explaining my City benefits, and I hereby authorize the City of Tucson to reduce my salary to cover any required payments for the benefits I have selected. Medical, Dental and the Flexible Spending Accounts (health care/dependent care) are deducted pre-tax. Other benefits are deducted after-tax. Domestic partner and domestic partner's children's premiums are deducted after-tax. **The portion of the premium paid by the City for domestic partners and their children is imputed income to the employee and will be added to your taxable wages on your W2.** I understand that by signing and submitting this form, I am making an election concerning my benefits for the plan year ending June 30, 2017. This election is binding, subject to my right to make changes according to the provisions of the program and subject to changes required to comply with state and federal laws. This Election Form is not an employment agreement.

I hereby certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Date: _____

Please return this form to: *City of Tucson Benefits Office*
255 W. Alameda, 3rd Floor, PO Box 27210, Tucson, AZ 85726 ***Phone:***520-791-4597 ***Fax:***520-791-5942

BENEFITS OFFICE USE ONLY:
Effective Date: _____ ☐ HRM ☐ Buck

Rev. June 2, 2015